NEW JERSEY NATIONAL GUARD SUMMER YOUTH CAMP
CAMP DATES: 15 August – 21 August 2004
CAMPER APPLICATION PACKET
NJNG FAMILY FOUNDATIONS, INC.

Dear Parent/Guardian:

Attached is a camper application packet for the NJNG Youth Camp. Please fill it out **COMPLETELY** and return it to the address on the bottom of this page. **ALL** pages must be filled out and mailed as a **complete package,** failure to do so will result in the application being returned to you as incomplete. Your child does not go on the Youth Camp Roster until all documents are complete and payment is made.

Boys and Girls, ages **9-12** are invited to apply. **ALL CAMPERS MUST BE, the Child/Grandchild/Legal dependent of an active or retired New Jersey National member. All children must be between the ages of 9-12 as of the first day of camp.**

The medical forms included in the packet are a prerequisite for acceptance into the program. State Law requires them and we cannot make exceptions. The deadline for applications is **15 June 2004**. All complete applications will be processed on first come and complete basis.

If your child is on medication, the attached **"permission to medicate"** and the **"Standing Orders"** form must be completed and **signed by your child's Physician and also signed by a parent/guardian**. It applies to both prescription and over-the-counter medication. **It is only required if your child will be taking medication while at camp. The "Permission to Medicate" form should be GIVEN TO THE CAMP NURSE AT IN-PROCESSING. DO NOT SEND BACK WITH APPLICATION.**

COST: $100.00 per child. Make check payable to NJNG Family Foundation, Inc. This fee supplements the cost of camper gear as well as activities and meals. All checks will be cashed upon receipt of the completed application. ($75.00 refund if child cancels more then 14 days before camp, no refund if child cancels within 14 days of camp)

Remember all applications must be sent in COMPLETE !!! to include copy of birth certificate and camp fee.

THANK YOU FOR YOUR INTEREST IN THE NJNG YOUTH CAMP
MAILING ADDRESS:

NEW JERSEY NATIONAL GUARD YOUTH CAMP
ATTN: CW4 RALPH W. CWIEKA, DPCS-CS
3650 SAYLORS POND ROAD
FORT DIX, NEW JERSEY 08640-7600
For further information, please contact CW4 Ralph W. Cwieka @ 609-562-0668
Or on the web at **www.state.nj.us/military/familysupport/**

CAMPER APPLICATION
NEW JERSEY NATIONAL GUARD
SUMMER YOUTH CAMP
SEA GIRT, NEW JERSEY
August 15 –August 21 2004

Must be submitted complete by **June 15th 2004** (**PLEASE PRINT**) all areas must be completed or application will be returned.

Child's Name: _____Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____

Age: _____(as of the first day of camp) Date of Birth: _____/_____/_____

T-Shirt Size (Adult sizes): S M L XL XXL

Has the child attended camp before? Yes No If yes when 2003 ,02, 01, 00, 99, 98

Parent(s) Name: _____

Is a sibling or family member attending or volunteering for camp? Yes __ No___

If so Name of individual _____

Emergency Phone # Day: ( ) _____Evening: ( ) _____

MILITARY SPONSOR INFORMATION MUST BE COMPLETED

NAME: _____Rank: _____ Active / Retired (circle)

SSN: _____ - _____- _____

UNIT: _____

"Children/Legal Dependents will be verified in DEERS"

Are you (Circle one): NJARNG / NJANG / NJ DMAVA/ Employee/Camp Vol

Relationship of Camper to Sponsor: (**Circle One**) Child / Grandchild / Legal Dependent

Other: _____

Applications must be received complete including Part A and Part B of Medical Forms, copy of birth certificate and application fee. Incomplete applications will be returned and not considered for acceptance until complete. Physicals must be less then 2 years old to be valid.

NEW JERSEY NATIONAL GUARD YOUTH CAMP HEALTH HISTORY AND EXAMINATION FORM

PART A TO BE COMPLETED BY THE PARENT/GUARDIAN

CAMPERS NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

DATE OF BIRTH: ____/_____/_____ PLACE OF BIRTH: _____

Parent/Guardian Name: _____ Relationship: _____

Telephone # Home: ( ) _____Work: ( ) _____

Name, address and phone number of nearest next of kin (other than Parent/Guardian):

Name: _____ Address:_____

City: _____State: _____ Zip: _____

Phone: ( ) _____

INSURANCE CARRIER: _____

Policy # _____

HEALTH HISTORY (COMPLETED BY PARENT/GUARDIAN)	YES	NO
1. Is the child under a physician's care now?	___	___
if yes, explain _____		
2. Has this child ever been medically advised not to participate in any kind of sports?	___	___
3. Is this child medically excused from physical education at the present?	___	___
3. Has He/She…		
a. Ever been unconscious after and injury?	___	___
b. Ever had a fracture or dislocation?	___	___
c. Ever had any surgery?	___	___
d. Within the last year, had to stay in a hospital overnight?	___	___
e. Ever experienced frequent chest pains or palpitations?	___	___
f. Ever experienced high blood pressure?	___	___

PART A CONTINUED:

5. Does this child. . .	YES	NO
a. Have a history of fainting with exercise?	___	___
b. Have a history of tiredness/fatigue?	___	___
c. Take any medications every day?	___	___
d. Have any allergies, including bee stings, hives, asthma?	___	___
e. Have a family history of sudden unexplained death under age 40?	___	___
6. Do you have any worries about his/her health or think that there may be any reason why he/she cannot participate in sports?	___	___

7. List any malfunctions or absence of a paired organ (eyes, kidneys, testes, etc).

8. Please list and explain any illness, injury, surgery, allergies and /or medications since his/her last physical.

9. Has your child been designated as a "special needs" child in his/her school district or defined as having "Attention Deficit Disorder".	___	___

PLEASE EXPLAIN ALL YES ANSWERS:

Signature of Parent _____ Date _____

PART B

TO BE COMPLETED BY PHYSICIAN

IMMUNIZATION RECORD

Name of Child (Last, First, MI)	Birth Date (Mo, Day, Yr) / /	Sex ☐ Male ☐ Female
PARENT/ GUARDIAN	**Name**	**Phone ( )**
	Address	

VACCINE TYPE	DISEASE DATE	1ST DOSE Mo/Day/Yr	2nd DOSE Mo/Day/Yr	3rd DOSE Mo/Day/Yr	4th DOSE Mo/Day/Yr	5th DOSE Mo/Day/Yr	6th DOSE Mo/Day/Yr
Diphtheria, Tetanus, Pertussis - DPT *if DT or TD, indicate in corner box		☐	☐	☐	☐	☐	☐
Oral Polio Vaccine (OPV) if Salk Vaccine, Indicate (IPV) in corner		☐	☐	☐	☐	☐	☐
MMR (Measles, Mumps & Rubella)							
Measles					Measles or Serology	Date	Titer
Rubella					Measles or Serology	Date	Titer
Mumps					Measles or Serology	Date	Titer
Other (Specify)							

DT Requires valid medical exemption	Provisional admission attached ☐ Date Granted:	Medical exemption attached ☐	Religious exemption attached ☐

TB Screening (Mantoux Test)	Date	Date	Date
Tested			
Read			
Result (MM)			

Chest X-Ray Date	Result Normal	Abnormal

Therapy
Case ☐ Reactor ☐
Date Started _____
Date Completed _____

HEALTH CARE RECOMMENDATION BY LICENSED PHYSICIAN

** I have examined the above camp applicant **within the past two (2) years**
Date Examined: _____/_____/_____

In my opinion, the above applicant ____is ____is not fit to participate in an active camp program.

The applicant is under the care of a physician for the following condition: _____
_____

Current Treatment (Include current medications, attached medication form): _____
_____

Explanation of any reported loss of consciousness, convulsion or concussion: _____
_____
Does applicant have epilepsy? Yes _____ No _____ Diabetes? Yes _____ No _____

Any treatment to be continued at amp_____
_____
Recommendations and Restrictions while at camp _____

PHYSICIAN SIGNATURE: _____ DATE: ___/_____/____
Printed Name: _____ Phone #: ( ) _____ - _____

STANDING ORDERS

for

OVER – THE – COUNTER MEDICATIONS

For NJ National Guard Youth Camp Campers and Staff

NAME: _____

ALLERGIES: _____

BENADRYL	12.5 mg 1-2 tabs PO q6 hours, as needed.
TUSSAFED	Ex.Srup 1 Tsp. PO q6 hours as needed
TYLENOL	325 mg 1-2 tabs PO q4 hours PRN headache, temp >101, generalized pain.
MOTRIN	200 mg 1-2 tabs PO q6 hours PRN headache, temp >101, generalized pain.
MYLANTA	over 48 pounds: 1-2 tabs (or 1-2 tsp) PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets (or 6tsps) per 24 hours.
TUMS ULTRA	1-2 tabs PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets per 24 hours.
1%HYRDRO-CORTISONE CREAM	Apply to affected area sparingly BID PRN itch.
PEPTO-BISMAL	1-2 tabs PO PRN upset stomach

Physician Signature: _____ Date: _____

Print: _____

Legal Guardian Signature: _____Date: _____

Print: _____

Dear Parent or Guardian,

1. No medication, prescription or non-prescription drugs (cough drops, aspirin, Tylenol, etc.) will be given to a child by the nurse unless it is received in the original container and accompanied by a written physicians **and** parental/guardian request.
2. All medications are to be held in the nurse's office with the parent/guardian assuming the responsibility for delivering such and picking up unused amounts at the end of Camp.
3. Prescription medication **must** be in the original pharmacy-labeled container.
4. Opportunities must be provided for child/parent/physician/nurse communications.
5. The physician must be consulted by the nurse whenever necessary to discuss medications being given to campers, including long-term use and possible abuse of any over-the counter medications.
6. **No camper** will be allowed to medicate him/herself during the camp.

PERMISSION TO MEDICATE FORM

An authorization form is required to be signed by the physician and the parent/guardian of any child who must receive medication during camp.

NAME OF CAMPER: _____

NAME OF PHYSICIAN: _____

NAME OF MEDICATION: _____

_____

TIMES AND DOSAGE TO BE TAKEN: _____

_____

LENGTH OF TIME MEDICATION WILL BE REQUIRED: _____

_____	_____	_____
DATE	NAME OF PHYSICIAN	SIGNATURE OF PHYSICIAN

_____	_____	_____
DATE	NAME OF PARENT	SIGNATURE OF PARENT

THIS FORM MUST BE RETURNED TO THE NURSE DURING IN-PROCESSING IF YOUR CHILD REQUIRES ANY MEDICATION WHILE ATTENDING CAMP. DO NOT RETURN WITH MAIN APPLICATION.

HOMETOWN NEWS RELEASE CONSENT FORM
(OPTIONAL)

If you desire, we will send a Hometown News Release to your local newspaper. The release will stress the following:

Camp Purpose: To provide a positive experience in a safe and caring environment and encourage our youth to feel good about themselves.

Camp Goals: To educate our youth on the hazards of substance abuse; becoming more responsible in maintaining our environment; and help youth cope with the stress of separation caused by military duty with the understanding of why their parent(s) / grandparent(s)/ guardian(s) volunteer to serve the state of New Jersey in the National Guard.

NEWSPAPER TITLE: _____

City: _____ State: _____

Fax #: of Newspaper: _____

Child's Name: _____

Parent(s) Name: _____

Home Address: _____

_____

Parent/Guardian Signature: _____

MEDICAL EMERGENCY AUTHORIZATION
THIS FORM MUST BE COMPLETED OR CHILD WILL NOT BE ABLE TO ATTEND CAMP.
THIS FORM MUST BE NOTARIZED !!!!!!!

In case of sudden illness or an accident to the below named participant, requiring immediate treatment or surgery while participating in the NJ National Guard Youth Camp Program, I authorize the Primary Staff or Medical Staff to take such action as deemed appropriate to protect the health and physical well-being of my child. This authority extends to any physician(s) and /or surgeons(s) selected by the Primary Staff to perform medical and/or surgical procedures including examination and tests necessary to preserve the life and well-being of my child.

All efforts will be made to contact the parent(s) or guardian(s) in case of an emergency.

Name of child: _____

Parent or Guardian: _____

_____

(Parent or Guardian Signature)

Address: _____

City, State, Zip: _____

Phone Number: _____

Work Number: _____

Cell Phone/Pager Number: _____

Doctors Name: _____

Doctor Phone Number: _____

Notary: _____

Date/Stamp/Seal

*******THE ABOVE MEDICAL EMERGENCY AUTHORIZATION STARTS ON 15 August 2004 AND EXPIRES ON 21 August 2004 UPON THE COMPLETION OF CAMP*******

IDENTIFICATION CARD INFORMATION

(PLEASE PRINT)

Child's Name: _____

Date of Birth: _____

Eye Color: _____ Hair Color: _____

Height: _____Feet _____Inches

Weight: _____

Parents/Guardians Name: _____

YOUTH CAMP APPLICATION ENCLOSURES

CHECK LIST

MAIN APPLICATION ☐

PART A EXAMINATION FORM ☐

PART B IMMUNIZATION RECORD ☐

STANDING ORDERS for Over Counter Medications ☐

PERMISSION TO MEDICATE (Bring to In-Processing)

HOMETOWN NEWS RELEASE FORM (optional) ☐

MEDICAL EMERGENCY AUTHORIZATION ☐

IDENTIFICATION CARD INFORMATION ☐

COPY OF BIRTH CERTIFICATE ☐

CHECK FOR $100.00

(PAYABLE TO NJNG FAMILY FOUNDATION INC.) ☐

PLEASE CHECK OFF ALL THE ABOVE FORMS AND SEND WITH YOUR APPLICATION PACKET. ALL OF THE ABOVE IS **REQUIRED TO QUALIFY FOR A COMPLETE APPLICATION PACKET.**